Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00003-10

Combined Assessment Program Review of the Jesse Brown VA Medical Center Chicago, Illinois

October 17, 2008

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

Table of Contents

Executive Summary

Introduction

During the week of July 21–25, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Jesse Brown VA Medical Center (the medical center), Chicago, IL. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 143 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

We returned to the medical center July 28–30 to further evaluate specific QM elements.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in five of the activities reviewed. For these activities, the medical center needed to:

- Implement a process for the use of relevant provider-specific performance information to assess competency and to support privileging decisions.
- Document committee attendance and discussion to support credentialing and privileging (C&P) decisions.
- Ensure that C&P folders and all C&P documentation meet Veterans Health Administration (VHA) and legal requirements.
- Meet the timeliness requirements for peer review and ensure that providers review all cases meeting the criteria specified by local policy.
- Consistently document the effectiveness of all pain medications within the required timeframe specified by local policy.
- Complete emergency department (ED) inter-facility transfer documentation, as required by VHA policy.
- Consistently complete intra-facility transfer documentation, as required by local Nursing Service policy.
- Consistently complete discharge documentation, as required by local policy.
- Check emergency carts, as required by local policy.
- Monitor refrigerators, as required by local policy.

- Display suicide prevention posters and brochures in highly visible areas throughout the medical center.
- Update the local hand hygiene policy to include the process for monitoring health care workers' adherence to required hand hygiene practices and consistently collect hand hygiene compliance data for all direct patient contact areas.
- Conduct environment of care (EOC) rounds weekly and inspect all medical center areas at least semi-annually.
- Develop action plans for EOC deficiencies.
- Ensure that all inpatient psychiatric staff receive training on environmental hazards that pose a threat to suicidal patients.

The medical center complied with selected standards in the following three activities:

- Pharmacy Operations.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia L. Solana, Director, and Dorothy Duncan, Associate Director, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations. (See Appendixes A and B, pages 21–27, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Introduction

Profile

Organization. The medical center is a tertiary facility located in Chicago, IL, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics—two in Chicago, IL; one in Chicago Heights, IL; and one in Crown Point, IN. The medical center is part of VISN 12 and serves a veteran population of about 325,000 throughout Cook County, IL, and Lake County, IN.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. It has 200 hospital beds and 33 transitional care/rehabilitation beds.

Affiliations and Research. The medical center is affiliated with the University of Illinois Medical Center at Chicago and with Northwestern University's Feinberg School of Medicine and provides training for 199 residents in 20 training programs. For fiscal year (FY) 2008, the medical center research program has 99 principal investigators, 290 active projects, and a budget of approximately $5.4 million. Important areas of research include alcoholism, nephrology, gastroenterology, hypertension, heart disease, chronic lung disease, diabetes, and the design and development of prosthetic devices.

Resources. In FY 2007, medical care expenditures totaled $246.7 million. The FY 2008 medical care budget is $290 million. FY 2007 staffing was 1,785 full-time employee equivalents (FTE), including 151 physician and 422 nursing FTE.

Workload. In FY 2007, the medical center treated 41,748 unique patients and provided 42,923 inpatient days in the hospital and 3,458 inpatient days in the transitional care unit. The inpatient care workload totaled 7,316 discharges, and the average daily census, including community living center[1] patients, was 127. Outpatient workload totaled 545,066 visits.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care.
- ED Operations.
- EOC.
- Medication Management.
- Pharmacy Operations.
- QM.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007 and FY 2008 through June 30, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois,* Report No. 07-00543-08,

October 18, 2007). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 143 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers supported the program's activities. We interviewed the medical center's Director, Chief of Staff (COS), and Quality Manager and other appropriate medical center staff. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care. Appropriate review structures were in place for 12 of the 14 program activities reviewed. However, we identified two program activities that needed improvement.

Credentialing and Privileging. Use of performance improvement data during the reprivileging process, documentation in committee minutes, and overall program documentation needed to be improved.

Performance Improvement Data. We reviewed 32 C&P folders and corresponding provider files to determine the use of performance improvement data in the evaluation of provider performance, judgment, and clinical competence and skills. Eighteen of the 32 (56 percent) provider files did not contain provider-specific performance data for use in the reprivileging process. Limited data was available in the remaining 14 files. These files contained quality assessment summary forms that included "yes," "no," or "not

applicable" checkmarks for the following categories: (a) medical record review/resident supervision, (b) medication use/patient safety, (c) use of blood products, (d) external peer review/performance monitors, (e) patient complaints/compliments, (f) invasive procedures care review, and (g) others as specified. The summaries we reviewed did not include quantifiable data, such as number of procedures performed, complication rates, and aggregate comparison data.

Surgical provider files did include National Surgical Quality Improvement Program (NSQIP) data with unadjusted complication and mortality rates. Because managers did not compare this information to other surgeons, we were unable to determine if individuals were outliers in their practices. We requested comparative information from the NSQIP nurse reviewer and noted that two surgeons had higher than average complication rates. The Chief of Surgery told us that he was aware of the rates and had reviewed those particular cases and determined that individual comparison was not meaningful due to case mix and severity of illness. However, there was no documentation that this information was reviewed prior to reprivileging.

The medical center's COS reported that the remaining service chiefs were in the process of being trained on the use of provider-specific data and that plans for implementation were being developed. We reviewed a specialty physician's file that contained documentation from another physician regarding quality of care concerns. The COS was aware of those concerns and reported that an oversight review process was in place for that physician. There was no quantifiable data to analyze if there were quality of care issues.

The medical center's bylaws and a local policy state that at the time of initial appointment, the service chief will establish and retain a quality assurance reprivileging/reappraisal file. This file should include provider-specific performance information and any aggregate data available for the purpose of comparison to peers or established benchmarks. The bylaws reference VHA requirements that state that ongoing reviews conducted by service chiefs must include activities emphasizing appropriateness of care, patient safety, and desired outcomes for potentially high-risk processes.[2] In

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

addition, the reappraisal process needs to include consideration of the number of procedures performed or major diagnoses treated, rates of complications compared with others doing similar procedures, any adverse results, and identification of trends in clinical practice. This data needs to be relevant and needs to be compared to others who hold the same or similar privileges

Ongoing practice evaluation provides the opportunity for service chiefs and medical staff leaders to identify clinical practice trends and determine the competence of independent practitioners to perform privileges granted by the medical center's Director. De-identified provider-specific data needs to be analyzed in a committee setting to determine practice patterns. Without this mechanism in place, negative practice patterns can be missed, and the implementation of safe, high quality patient care improvements is compromised.

Committee Minutes Documentation. We reviewed minutes from the Professional Standards Board (PSB), the Medical Executive Committee (MEC), and the Executive Session of the MEC. We determined that minutes did not adequately document discussion to support C&P decisions. Although the facility kept separate attendance rosters for meetings, the minutes did not include member attendance, which made it impossible to determine if the required decision-making quorum was present.

According to VHA policy, minutes of the MEC must reflect documents reviewed and the rationale for determining clinical competence to support the granting of requested privileges. Documentation in MEC minutes was limited to "accept recommendations of PSB meeting." PSB and Executive Session of the MEC minutes did not contain any discussion. These minutes had scripted statements for granting privileges and simply listed names of providers and their respective services and status (for example, "fee-basis," "part-time," "contract"). Also, these minutes stated that "exceptions are noted in the narrative next to the practitioner," but there were no narratives. There were requests for withdrawal of privileges, but no reasons were noted. Two consecutive months of minutes from the Executive Session of the MEC noted the disapproval of a specialty physician, but no physician was listed for that service. This gives the impression that the narrative

paragraphs of the minutes were copied from previous months.

Without adequate, accurate, and complete clinical staff discussion and documentation, the medical center's Director cannot make informed decisions for granting or renewing privileges.

Credentialing and Privileging Program Documentation. We found concerns with overall program documentation. Appendix A of VHA Handbook 1100.19 includes the requirements for a standard C&P folder. While this folder can be electronic or hard copy, it must contain specific sections in the order specified to maintain continuity within VHA. The C&P folders were not standardized. Sections were misfiled, and liquid ink was used on a clinical privileges request form. Check marks instead of initials were present on requested and approved columns of forms, allowing for easy altering of requests. The medical center had changed the process for the new reprivileging cycle, but the folders we reviewed did not consistently reflect the recent changes.

Peer Review. One of 13 peer reviews did not meet VHA required timeframes for completion. We reviewed peer review reports for quarters 1–3 of FY 2008 and found that in the 1st quarter, 12 of 13 peer reviews were completed timely. QM staff reported that the reviewing physician misplaced the one delinquent peer review. VHA requirements for the peer review process state that the initial review must be completed within 45 days and the final review within 120 days. This review did not meet either timeframe. Peer reviews are an important component of quality programs and can improve care by giving timely feedback to providers about the quality of their care.

The peer review log for FY 2007 listed 41 completed reviews. The Peer Review Committee (PRC) annual summary report stated that 29 cases were mortality reviews brought forth from QM staff and that 12 were clinical service referrals. PRC minutes stated that there is an expectation to review a larger pool of cases and recommended that more cases come from the COS and section chiefs. The local peer review policy specifies seven major groups for consideration for peer review.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director implements a process for the use of

relevant provider-specific performance information to assess competency and to support privileging decisions.

The VISN and Medical Center Directors concurred with our findings and recommendation. A C&P process for reviewing provider-specific data has been implemented. The COS will monitor the process and report compliance to the PSB on a quarterly basis. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that committee minutes document meeting attendance and discussion to support C&P decisions.

The VISN and Medical Center Directors concurred with our findings and recommendation. The process for documentation of minutes has been revised to include attendance and discussion of C&P decisions. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that C&P folders and all C&P documentation meet VHA and legal requirements.

The VISN and Medical Center Directors concurred with our findings and recommendation. C&P folders will be organized to include all elements required in VHA Handbook 1100.19. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that all peer reviews meet the timeliness requirements and that providers review all cases meeting the criteria specified in local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. All components of the peer review process are in place and in compliance with VHA policy. Peer reviews will be continuously tracked and monitored. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed selected medication management processes in the inpatient acute medical/surgical, mental health, long-term care, telemetry, and intensive care units. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to correctly identify patients prior to medication administration. We found one area that needed improvement.

Documentation of Pain Medication Effectiveness. On several units we reviewed, nurses did not consistently document the effectiveness of pain medications, as required by local policy and nursing guidelines.

We reviewed the Bar Code Medication Administration (BCMA) records for 14 patients who were hospitalized in selected units at the time of our visit. Nurses administered a total of 48 doses of pain medications to these patients. For each patient, we reviewed documentation for several doses of pain medication. The effectiveness of 36 of the 48 (75 percent) doses of pain medications was documented within 4 hours, as required by local policy. Without appropriate follow-up and consistent documentation, clinicians could not be assured that patients' pain was effectively managed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. Medication effectiveness is monitored on a weekly basis and reported through the BCMA Committee. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Emergency Department Operations

The purpose of this review was to evaluate whether VHA facility EDs complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients

transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's ED and triage environments for cleanliness and safety.

The ED is open 24 hours per day, 7 days per week and is located within the main hospital building. The emergency services provided are within the medical center's patient care capabilities. There is an appropriate policy for managing patients whose care may exceed the medical center's capability.

We reviewed medical records of patients who presented in the ED with acute mental health conditions, and in all cases, we found that staff managed the patients' care appropriately.

We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. We also found that managers had appropriately documented nurse competencies.

We determined that the ED complied with VHA operational standards, including staffing guidelines, cleanliness, and competency. However, the inter-facility transfer procedures and the nourishment refrigerator checks did not follow policy. Specific findings for refrigerator checks are discussed in the EOC section of this report.

Inter-Facility Transfers. ED staff did not document specific inter-facility transfer data, as required by VHA policy.[3] The movement of acutely ill people from one institution to another exposes them to risks. Failing to transfer patients may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately to assure maximum patient safety and to comply with the intent of the Emergency Medical Treatment and Labor Act.

None of the medical records we reviewed contained all the required documentation elements. During onsite interviews with ED staff, they confirmed that they did not always complete required documentation.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete

[3] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

inter-facility transfer documentation, as required by VHA policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. An action plan to review 100 percent of the transfers from the ED has been developed. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, transfers, and discharges were coordinated appropriately and met VHA and Joint Commission (JC) standards. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 12 inpatients that had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes.

We identified the following areas that needed improvement:

Intra-Facility Transfers. We found that 8 of 10 (80 percent) intra-facility transfers had the required medical record documentation, as specified by local Nursing Service policy. Local policy requires that the transferring nurse give a verbal report to the receiving nurse and that nursing staff complete appropriate documentation templates for each transfer. Completion of reports and documentation facilitates communication.

Discharges. We determined that 11 of 14 (79 percent) discharges had the required medical record documentation, as specified by local policy. Local policy requires staff to provide discharge instructions to the patient and/or significant other and to document an evaluation of the understanding of the instructions.

Documentation and communication of patient health information ensures coordination of care. Failure to document and report all health care information impedes continuity and appropriate coordination.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently

complete intra-facility transfer documentation, as required by local Nursing Service policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. Monthly medical record monitoring is being conducted to ensure the expected 90 percent compliance rate. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete discharge documentation, as required by local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. A focused medical record review for discharge documentation has been initiated. Action plans will be developed for identified issues, and tracking will be through the Medical Record Committee. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Environment of Care

The purpose of this review was to determine if VHA medical centers comply with selected IC standards and maintain a clean and safe health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and JC standards.

We inspected the ED, outpatient clinic areas, inpatient units, intensive care units, the inpatient dialysis unit, the transitional care unit, and the outpatient laboratory area. The medical center maintained a generally clean and safe environment. Nurse managers and unit staff expressed satisfaction with the responsiveness of the housekeeping staff in their areas.

We inspected the locked acute inpatient psychiatric unit to determine if managers identified environmental hazards that pose a threat to suicidal patients and to ensure that staff received specialized training on identifying these hazards. Medical center managers conducted quarterly mental health EOC assessments for the locked inpatient psychiatric unit,

as required by VHA, and staff were pursuing corrective actions.

We identified the following areas that needed improvement:

Emergency Cart Checks. Medical center staff did not consistently check emergency carts once each shift, as required by local policy. We inspected six patient care areas and found three areas where emergency carts had not been checked at least once each shift during the prior 30 days. Checking emergency carts each shift ensures that appropriate equipment is readily available and functioning.

Refrigerators. Staff did not consistently conduct refrigerator monitoring, as required by local policy. We found the following:

- Outdated food stored in a patient nourishment refrigerator on an inpatient unit.
- Staff food stored in the medicine refrigerator in the outpatient laboratory.
- Daily refrigerator temperature checks not completed for nourishment refrigerators for 4 days in the outpatient clinic and for 7 days in the ED.

Local policy requires that refrigerators be cleaned weekly and leftover food discarded, that separate refrigerators be maintained for medicine and nourishment, and that refrigerator temperatures be checked and documented daily. Potentially harmful organisms can develop and grow in nourishment products that are outdated or that are stored in refrigerators with temperatures that are out of range. In addition, storing food with medicine could potentially lead to contamination.

Suicide Prevention Information. Suicide prevention posters and brochures were not consistently displayed in highly visible areas throughout the medical center, as required by a Deputy Under Secretary for Health for Operations and Management (DUSHOM) memorandum issued on December 7, 2007. During our review, we found some suicide brochures in one clinic area, but we did not find suicide prevention posters or brochures displayed in highly visible areas throughout the rest of the medical center.

Hand Hygiene. While the medical center had implemented an extensive hand hygiene awareness campaign and

installed hand hygiene products, the local hand hygiene policy did not include the process for monitoring health care workers' adherence to the required hand hygiene practices. In addition, hand hygiene compliance data were not consistently gathered for all direct patient contact areas. For example, hand hygiene data were not compiled for mental health areas, the laboratory, radiology, and two outpatient clinics.

VHA requires that medical centers have a hand hygiene policy that outlines the process for monitoring health care workers' adherence to the required hand hygiene practices and that provides information regarding their performance. IC staff needed to monitor, trend, analyze, and report hand hygiene data from all direct contact areas in order for clinicians to implement quality improvements to reduce infection risks for patients and staff.

Environment of Care Rounds. While the medical center was conducting EOC rounds, it was not adhering to a consistent weekly schedule. Medical center EOC inspection team rounds allow managers to identify and correct sanitation discrepancies, unsafe working conditions, and OSHA regulatory violations. A DUSHOM memorandum issued on March 5, 2007, delineated that environmental rounds be completed weekly and that all areas be inspected at least semi-annually.

The medical center had not developed action plans for EOC deficiencies for quarters 1–3 of FY 2008. As part of the VHA performance monitors, each facility must develop a plan that documents actions needed to address EOC deficiencies that cannot be corrected within 14 days. At the time of our review, the medical center had 362 incomplete items that required follow-up. A former employee was responsible for the action plans, and managers could not find any plans after his departure. Senior managers told us that they were aware of the requirement and were implementing a process for the correction of EOC deficiencies.

Locked Acute Inpatient Psychiatric Unit. Some staff members working on the locked inpatient psychiatric unit did not receive training on identifying and correcting environmental hazards. Twenty of 54 (37 percent) staff members had not received this training. A memorandum issued on August 27, 2007, by the DUSHOM requires that all staff who work on locked inpatient psychiatric units receive

training on environmental hazards that represent a threat to suicidal patients.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires staff to check emergency carts, as required by local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. A hand-off checklist between shift charge nurses will include the emergency cart check. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor refrigerators, as required by local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. An electronic refrigerator temperature monitoring program will be fully implemented. Pharmacy and nutrition monitors are in place, as required by local policy. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that suicide prevention posters and brochures are displayed in highly visible areas throughout the medical center.

The VISN and Medical Center Directors concurred with our finding and recommendation. Suicide prevention posters and brochures have been placed in prominent areas throughout the medical center. We find this corrective action acceptable, and we consider this recommendation closed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that staff update the local hand hygiene policy to include the process for monitoring health care workers' adherence to required hand hygiene practices and that staff consistently collect hand hygiene compliance data for all direct patient contact areas.

The VISN and Medical Center Directors concurred with our findings and recommendation. Monitoring of hand hygiene compliance has been expanded to include mental health units and ancillary services. The local hand hygiene

monitoring policy has been revised and approved. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires staff to conduct EOC rounds weekly and inspect all medical center areas at least semi-annually.

The VISN and Medical Center Directors concurred with our finding and recommendation. EOC rounds will be completed weekly, and all areas will be inspected at least semi-annually. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires staff to develop action plans for EOC deficiencies.

The VISN and Medical Center Directors concurred with our finding and recommendation. EOC deficiencies will be tracked, and review documentation will be available in EOC Committee minutes. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 15 We recommended that the VISN Director ensure that the Medical Center Director requires that all staff who work on the locked inpatient psychiatric unit receive training on environmental hazards that pose a threat to suicidal patients.

The VISN and Medical Center Directors concurred with our finding and recommendation. The medical center provided documentation that all mental health staff have completed the required training. We find this corrective action acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Pharmacy Operations

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances and the pharmacies' internal physical environments. We also determined whether clinical managers had processes in

place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We assessed whether the medical center's policies and practices were consistent with VHA regulations governing pharmacy and controlled substances security.[4] Additionally, we reviewed policies and procedures and interviewed appropriate personnel to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns, and we interviewed appropriate Pharmacy Service and Police and Security Service personnel as necessary.

Pharmacy Controls. Our review demonstrated that the medical center had appropriate policies and procedures to ensure the security of the pharmacies and controlled substances. Controlled substances inspections were conducted according to VHA regulations. Training records documented that the Controlled Substances Coordinator (CSC), the Alternate CSC, and all 21 inspectors received appropriate training to execute their duties. The pharmacies' internal environments were secure, clean, and well maintained. The sterile preparation area's Class 5 hood, where sterile intravenous medications were prepared, complied with VHA regulations and IC standards.[5]

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[6] Some literature suggests that

[4] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.
[5] VHA Handbook 1108.6.
[6] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.

that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[7]

Clinical pharmacists identified all patients who were prescribed nine or more medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the medical center had developed a Nursing Service staffing plan and unit-based nurse staffing guidelines, and we found them to be adequate.

The medical center uses hours per patient day as the primary staffing methodology. Nurse managers adjust staffing on a shift-by-shift basis based on patient acuity levels; average daily census; and frequency of patient admissions, transfers, and discharges. The Nursing Service staffing plan is reviewed and adjusted annually. We suggested that unit-based guidelines be dated so that annual updates can be tracked.

We reviewed staffing for 8 inpatient units and for the outpatient clinics for a total of 75 shifts. We looked at one holiday, one Saturday, and one Wednesday for all units. We found that local guidelines for nurse staffing were met in all areas reviewed and that specific actions had been taken to ensure safe patient care, including the use of compensatory time and overtime when needed. We found nurse staffing adequate in all patient care areas.

We made no recommendations.

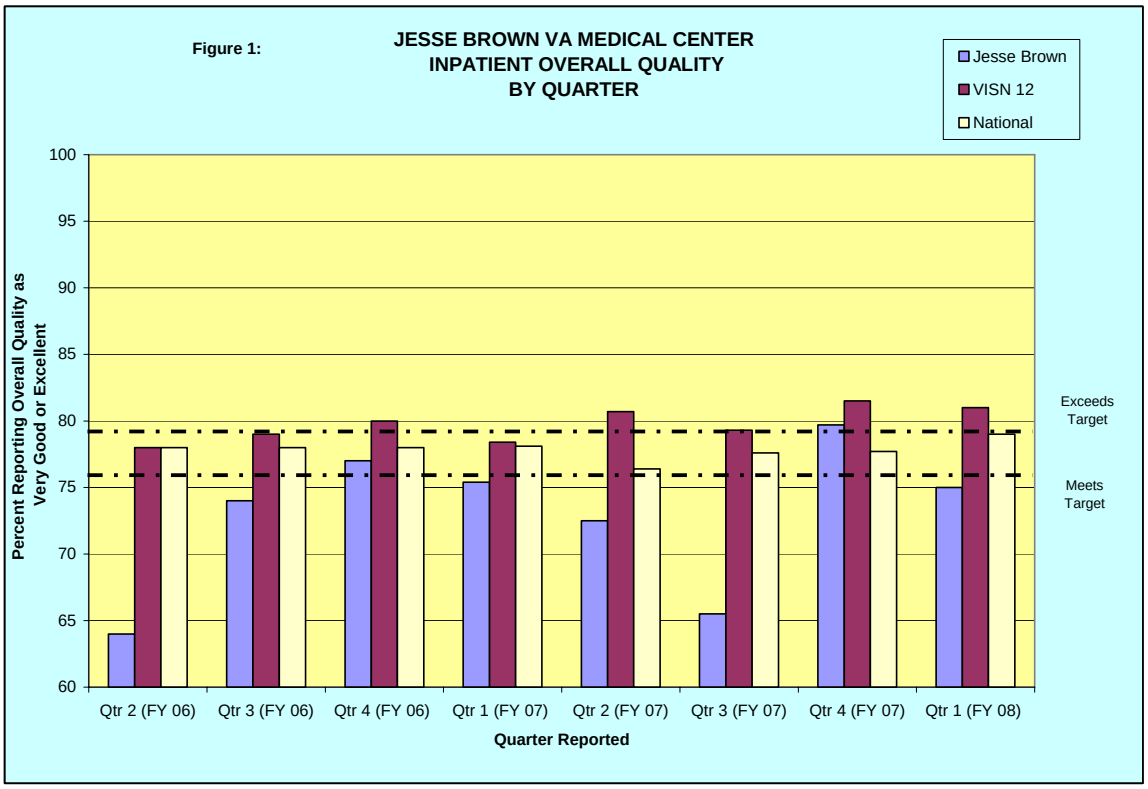
Survey of Healthcare Experiences of Patients

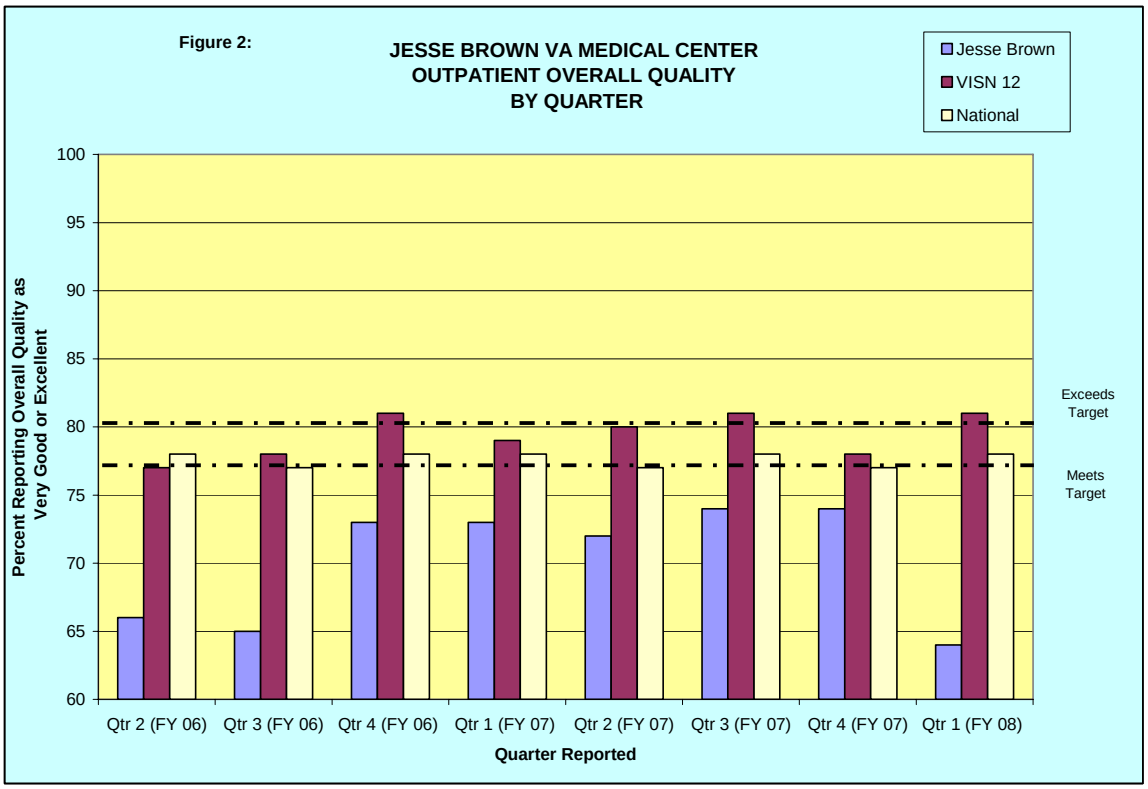
The purpose of this review was to assess the extent that VHA medical centers use quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological,

[7] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 2nd quarter of FY 2006 and ending with the 1st quarter of FY 2008. Figures 1 and 2 below and on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.





In the previous CAP report, we made a recommendation for the SHEP process. The medical center did not have a SHEP coordinator, a process to fully analyze SHEP data, or a mechanism to develop action plans to improve areas that fell below target goals. SHEP data was not shared with staff or service chiefs, and the Service Excellence Committee (SEC), which had oversight responsibility for patient satisfaction, did not adequately review SHEP data or address deficiencies.

The SEC was restructured to include representatives from various services and was renamed as the Standards of Behavior Council (SBC). A new SHEP coordinator was selected, and the medical center developed and implemented a comprehensive SHEP program that includes data analysis, service-level input to the SBC, and corrective action planning and follow-up. The medical center identified opportunities for improvement based on the SHEP scores and developed action plans targeting specific services. Staff provided documentation of the implementation of action plans, ongoing activities, and action plan effectiveness.

The data available includes the 1st quarter of FY 2008, but insufficient time has passed to reflect the impact of the many changes implemented. Because the medical center had implemented action plans to correct deficiencies, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 17, 2008

From: Director, Veterans Integrated Service Network (10N12)

Subject: **Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, IL**

To: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

Director, Management Review Service (10B5)

I have reviewed and concur with the attached plan provided by Jesse Brown VAMC.

James W. Roseborough, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 9, 2008

From: Director, Jesse Brown VA Medical Center (537/00)

Subject: **Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, IL**

To: Director, Veterans Integrated Service Network (10N12)

The attached response is being submitted regarding the CAP Review on behalf of the Jesse Brown VA Medical Center.

JAMES S. JONES

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director implements a process for the use of relevant provider-specific performance information to assess competency and to support privileging decisions.

Concur

The Credentialing and Privileging process for reviewing provider specific data has been developed and implemented. Each of the providers reviewed in the Professional Standards Board (PSB) will be required to have provider specific data to include, as applicable; NSQIP data, complication rates and major diagnoses treated, as well as adverse outcomes in clinical practice. De-identified provider specific data will be analyzed in PSB to review practice patterns. These data will be compared to aggregate data and available national benchmarks and the analysis will be recorded in the PSB meeting minutes reflecting the discussion and action plans identified. The Chief of Staff will monitor the process and report compliance to the PSB on a quarterly basis.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that committee minutes document meeting attendance and discussion to support C&P decisions.

Concur

The process for documentation of minutes has been revised to include the attendance roster in the minutes. The meeting minutes have been expanded to include discussion to support C&P decisions. JB requests closure of this recommendation.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that C&P folders and all C&P documentation meet VHA and legal requirements.

Concur

C&P folders will be organized to reflect all elements required in VHA Handbook 1100.19. To ensure consistency and at the advice of OQP

Credentialing Section, all privileges will be initialed next to each privilege block identifying "Yes or No" requested for all future initial and renewal of privileges. No blanks or lines will be seen in privilege section. Liquid ink will not be permitted. All clinical service chiefs have been educated on September 3, 2008, at the PSB meeting. Chief of Staff will ensure that all C&P folders are consistent with these items during PSB and Medical Executive Committee (MEC) meetings.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that all peer reviews meet the timeliness requirements and that providers review all cases meeting the criteria specified in local policy.

Concur

One file was outside the allowable dates for peer review completion. All components of the Peer Review Process are in place and in compliance with the VHA directive. Meeting minutes reflect and demonstrate full compliance with all requirements. With the initiation of the occurrence screening process by October 1, 2008, the clinical peer review should increase the volume for peer review activity as recommended. All peer reviews will be continually tracked in a data base with the due date identified and monitored. The peer review committee meetings will be held regularly as identified and will ensure compliance with the regulations. In addition, peer review timelines are reported and reviewed by the VISN Peer Review Committee on a quarterly basis.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

Concur

Action plans have been identified for the outlier patient care areas. On a weekly basis, prn effectiveness is monitored and outliers are identified and responsible parties are individually reeducated in the process of documentation requirements. The BCMA effectiveness and action plans will be tracked through the BCMA Committee. This committee reports this information to the Pharmacy and Therapeutics Committee.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete inter-facility transfer documentation, as required by VHA policy.

Concur

The issue of documentation for inter facility transfer was identified in the recent annual Periodic Performance Review for the Joint Commission submitted in July 2008. The action plan developed included the medical record review of 30 transfers or 100% that occurred from the Emergency Department. This information will be reported to the Medical Record Committee on an ongoing basis until maintenance of the process is demonstrated.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete intra-facility transfer documentation, as required by local Nursing Service policy.

Concur

Intra-facility transfer documentation requirements have been identified in the Jesse Brown policy. The issue of documentation for intra facility transfer was identified in the recent annual Periodic Performance Review for the Joint Commission submitted in July 2008. Monthly medical record monitoring is being conducted for the expected 90% compliance rate and reported to the Medical Record Committee.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete discharge documentation, as required by local policy.

Concur

An additional focused medical record review for discharge review has been initiated and will be completed this month. Identified issues will have action plans developed, monitored and tracked through the Medical Record Committee. Documentation of patient receipt and understanding of the discharge instructions will be noted in the medical record and tracked until 90% compliance is maintained.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires staff to check emergency carts, as required by local policy.

Concur

Emergency carts are to be checked in all inpatient areas once a shift. The hand off checklist between shift charge nurses will now include checking that the crash cart was checked on that previous shift. The process for outpatient clinics will be at the end of the day at which time the charge nurse will verify that the crash cart has been checked and initialed. A random sample review of this process will be conducted monthly and reported to the CPR committee.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor refrigerators, as required by local policy.

Concur

The Temp Trak electronic refrigerator temperature monitoring program is currently being implemented throughout the facility for all refrigerators. Full implementation of this program is planned for September 19, 2008. All staff have been educated, monitors installed and manuals provided for each area for future reference. Additionally, pharmacy and nutrition monitors are in place for monitoring all refrigerators for compliance on a weekly basis and checking for expiration of medications and food as well as separating these items from storage in the same refrigerator. These issues are also reviewed on the weekly Environment of Care (EOC) rounds and tracked until compliant.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that suicide prevention posters and brochures are displayed in highly visible areas throughout the medical center.

Concur

Suicide prevention posters were placed throughout the medical center including the main patient waiting areas in PAS, entry way from Damen Avenue with the OIF/OEF posters, hallway on 2W leading to rehab, all patient waiting areas, primary care clinics, in all elevators, waiting areas by Compensation and Pension, Women Health Clinic, all Cobs, and Emergency Department. Suicide brochures are also available for patient education. Jesse Brown requests closure of this recommendation based upon the implemented action plans.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that staff update the local hand hygiene policy to include the process for monitoring health care workers' adherence to required hand hygiene practices and that staff consistently collect hand hygiene compliance data for all direct patient contact areas.

Concur

Monitoring of hand hygiene compliance has been expanded to include the mental health units and ancillary services. Infection Control Representatives have been identified and trained to monitor hand hygiene compliance for these expanded areas. The issue of the ancillary services and mental health areas hand hygiene monitoring was identified as an action plan for the 2008 Joint Commission Periodic Performance Review. These patient care areas have been added to the listing for monthly

monitoring of hand hygiene. VISN 12 Infection Control Committee requires monthly reporting of the hand hygiene reporting which includes trending, analysis and action plans when needed. JBVAMC Infection Control Meeting minutes will document the evidence for tracking, trending, and analysis of the hand hygiene monitoring being conducted monthly. The local policy has been revised and approved for the process for hand hygiene monitoring.

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director requires staff to conduct EOC rounds weekly and inspect all medical center areas at least semi-annually.

Concur

All weekly Environment of Care (EOC) rounds will be completed in the week identified and documented in the Environment of Care Meeting Minutes providing for tracking of EOC rounds ensuring continual compliance that all areas are reviewed on a semi annual basis. A table of data regarding this documentation will be in the EOC minutes on a quarterly basis.

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires staff to develop action plans for EOC deficiencies.

Concur

As of Q4, Environment of Care (EOC) deficiencies are placed in a database for tracking and monitoring until completion within the required 14 days. All EOC rounds and EOC deficiencies database tracking will be tracked and documentation will be available of this review in the Environment of Care Committee meeting minutes. The EOC Committee meeting minutes are reported in the Quality Leadership Council quarterly by the Associate Director.

Recommendation 15. We recommended that the VISN Director ensure that the Medical Center Director requires that all staff who work on the locked inpatient psychiatric unit receive training on environmental hazards that pose a threat to suicidal patients.

Concur

All staff have now completed the required training. The Suicide Prevention Coordinator will continue to track annual compliance. Jesse Brown requests closure of this recommendation.

OIG Contact and Staff Acknowledgments

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